Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
		IL6004592	B. WING		11/2						
NAME OF I	PROVIDER OR SUPPLIER	STREET AD		DRESS, CITY, STATE, ZIP CODE							
HERITAGE HEALTH-HOOPESTON  423 NORTH DIXIE HIGHWAY HOOPESTON, IL 60942											
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE					
S 000	S 000 Initial Comments		S 000								
	FRI of 11/16/2021\II	_140534									
S9999	Final Observations		S9999								
	Statement of Licensure Violations										
	300.1210b)5 300.1210c) 300.1210d)6)										
	Section 300.1210 G Nursing and Person	General Requirements for all Care		ęs							
	and services to attai practicable physical, well-being of the res each resident's com plan. Adequate and care and personal care	provide the necessary care in or maintain the highest mental, and psychological ident, in accordance with prehensive resident care properly supervised nursing are shall be provided to each total nursing and personal sident.	ΣJ								
	transfer activities as	with ambulation and safe often as necessary in an etain or maintain their highest		8							
	c) Each direct care be knowledgeable al respective resident of	giving staff shall review and bout his or her residents' are plan.									
U	d) Pursuant to substance shall include, at and shall be practice seven-day-a-week between of Public Health			Attachment A Statement of Licensure Viole	itions						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 12/28/2021 FORM APPROVED

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED IL6004592 B. WING 11/20/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **423 NORTH DIXIE HIGHWAY HERITAGE HEALTH-HOOPESTON** HOOPESTON, IL 60942 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 1 S9999 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were not met as evidenced by: Based on record review and interview the facility failed to implement care planned fall interventions to prevent a fall for one of three residents (R11) reviewed for falls on the sample list of 13 residents. R11 fell and sustained a displaced spiral humerus (arm) fracture when staff failed to utilize two staff for a transfer and failed to implement nonskid floor strips. Findings include: R11's undated Face Sheet documents an admission date of 12/4/12 and diagnoses of: COVID-19 on 11/9/21, Acute Embolism and Thrombosis of Deep Veins of Right Lower Extremity and Cellulitis Right Lower Limb on 11/4/21, Closed Displaced Spiral Fracture of Right Humerus on 11/16/21 and History of Falling and Difficulty in Walking. R11's Minimum Data Set (MDS) dated 10/14/21 documents a Brief Interview for Mental Status score of 5 out of 15 possible points indicating severe cognitive impairment. This same MDS documents R11 as requiring extensive assistance of two staff for transfers, bed mobility, dressing, toileting and personal hygiene. R11's Care Plan intervention dated 10/11/21 documents R11 requires two staff for transfers

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		IL6004592	B. WING			C 20/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, STATE, ZIP CODE		117.	11/20/2021	
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	<u> </u>	HOOPEST	TON, IL 609	42			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
\$9999	Continued From page 2		S9999				
	when R11 has acute Plan intervention da to have non-skid str	e illness. This same Care ted 6/30/20 documents R11 is ips on floor.					
	R11's Fall Scale Ass documents Fall risk a high fall risk.	sessment dated 11/11/21 score of 75 indicating R11 as					
	November 1-30, 202 order dated 11/4/21 (mg) twice a day for 11/13/21 twice a day Lower Extremity Cell documents a Physici Doxycycline Monohyseven days and agai	er Sheet (POS) dated 21 documents a Physician for Amoxicillin 500 milligrams seven days and again on for three days for Right ulitis. This same POS an order dated 11/4/21 for drate 100 mg twice a day for n 11/13/21 twice a day for Lower Extremity Cellulitis.					
	4:40 AM V32 Registe "dependent pitting ed	s Note dated 11/16/21 at ered Nurse (RN) documents lema in Right Lower Leg" and balance is poor."					
	documents "Patient (I transferred at facility a Complains of pain to deformity." This same documents "X-Ray im of the Proximal Right	al Record dated 11/16/21 R11) stated was being and was dropped by (V31). right shoulder. Obvious e Hospital record pression: Oblique Fracture Humerus and Widening of ricular (AC)joint suggesting					
	Health (IDPH) dated 1 was diagnosed with C has had increased we COVID-19. (R11) has	Illinois Department of Public 1/18/21 documents "(R11) OVID-19 on 11/9/21 and akness since getting not been able to ambulate sisting with transfers into					

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ COMPLETED B. WING IL6004592 11/20/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 423 NORTH DIXIE HIGHWAY **HERITAGE HEALTH-HOOPESTON** HOOPESTON, IL 60942 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 3 S9999 wheelchair. (R11) went to stand up with staff assisting and (R11) feet started to slide out, (V31 Certified Nurse Aide (CNA)) put (V31) forearm under (R11) right arm as (R11) was sliding and that is when (V31) heard a pop sound and lowered (R11) to the floor. Due to right arm pain and no range of motion in right arm, (R11) was sent to the local emergency room for evaluation and treatment. (R11) was noted to have a Closed displaced Spiral fracture of shaft of Right Humerus." On 11/20/21 at 11:15 AM R11 stated "the girl (V31) CNA) was trying to get me up when my feet slipped out from underneath me. She (V31) grabbed me to keep me from falling on the floor. (V31) grabbed me under my right armpit and that's when we (V31, R11) heard a loud pop noise. Oh, it hurt so bad. I couldn't move my arm." R11 stated "they (facility) didn't do anything wrong but let me fall and break my arm." On 11/20/21 at 3:20 PM V29 Nurse Practitioner confirms R11 was being treated with antibiotics for newly diagnosed Right Lower Extremity Cellulitis which began on 11/4/21 and was diagnosed with Right Lower Leg DVT (Deep Vein Thrombosis) on 11/6/21. V29 confirmed that R11 was diagnosed with COVID-19 on 11/9/21. V29 stated "COVID-19, Cellulitis and a DVT are acute illnesses." On 11/20/21 at 2:00 PM V3 Assistant Director of Nurses (ADON) stated "(R11) was diagnosed with COVID-19 on 11/9/21 and moved to another room on the COVID-19 unit. We (facility) did not make sure the non-skid strips were on the floor. We (facility) missed it. The non-skid strips should

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have been on the floor. (R11) fall could have been prevented." V3 confirmed R11 was recently

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